interesting. There was no enlargement of the organ, and the left chambers, with their valves, were normal. On opening the right auricle so as to look down on the tricuspid valve, there were seen two crumbling masses of vegetation, three-quarters of an inch long and one-half inch high, flattened from side to side, looking upward toward the auricle, and separating somewhat toward the remaining valve. This valve was unaffected, except for ulcerated points where closure made pressure against the verrucose growths.

The case is interesting, not only from its rarity and the absence of auscultatory symptoms pointing to disease of the heart, but on account of its obscure etiology. There had been no antecedent rheumatism, no valvular disease, no trauma, no previous illness, no urethritis, and the patient was a seafaring man, breathing the purest air.

Progressive Muscular Dystrophies.

Under this title Sachs in a very valuable paper (*N. Y. Medical Journal*, Dec. 15, 1888) includes those forms of disease in which a primary progressive wasting of some or all of the muscles of the body is the most characteristic feature, and in which the wasting (atrophy) may or may not be associated with true pseudo-hypertrophy of some of the muscles. Though these primary muscular dystrophies are the chief subject of his discussion, he first devotes considerable attention to typical spinal muscular atrophy, since a very large number of cases of the peripheral type as well as of different spinal forms were once classed under this term.

The author next considers in order and in detail the different forms of primary muscular atrophy, reviewing thoroughly the literature of the subject, quoting cases from his own experience and that of others, and describing the histological conditions and differences as far as known. He ends his paper with the following conclusions:

1. Progressive muscular atrophy, type Aran-Duchenne, is due to spinal cord disease. The peroneal type of progressive muscular atrophy bears close resemblance to this form and may possibly have a similar pathology.

2. Duchenne's type of progressive muscular atrophy might be termed the hand type, while the peroneal form would represent the leg type.

3. Pseudo-hypertrophy is not of spinal origin. Lipomatosis is a mere incident in the course of the disease and is associated with widespread atrophy in various parts of the body.

4. There is a close relationship between pseudo-hypertrophy and Erb's juvenile form of progressive muscular atrophy, but not an absolute identity. This close relationship is marked by the onset of the diseases at an early age, by the entire absence of fibrillar contractions in both forms, by the absence of reaction of degeneration, and by the occurrence of lipomatosis some time during the course of the disease. They differ from each other in the distribution of the muscular atrophy, and possibly in the histological changes in the affected muscles.

5. Hereditary muscular atrophy does not deserve the rank of a separate clinical entity, all forms of primary myopathies being occasionally hereditary.

6. The type of Landouzy and Déjérine is closely related to Erb's form, the

additional involvement of the face muscles not being sufficient basis for a wide clinical differentiation.

7. Pseudo-hypertrophy and Erb's form should be regarded as the two representative forms of primary progressive dystrophies.

8. Primary progressive dystrophies are distinguished from spinal progressive dystrophies by their cardinal symptoms, the onset at an early age, the occurrence of true or false hypertrophy, the absence of the reaction of degeneration, and the absence of fibrillar contractions.

As the term "progressive muscular atrophy" has been widely used as a general title, the author substitutes for it Erb's designation "spinal progressive amyotrophia."

Believing that the anatomical distribution of atrophies or hypertrophies does not form a sufficient basis for classification, he would reduce the classification to the following simple form:

1. Amyotrophia spinalis progressiva:
   a. Hand type;
   b. Leg type—peroneal form.
2. Primary progressive dystrophies:
   a. Pseudo-hypertrophy;
   b. Erb's form.

The description of the exact anatomical distribution of the cases under Class 2 may be left to the individual author.

SURGERY.

UNDER THE CHARGE OF

J. WILLIAM WHITE, M.D.,

PROFESSOR OF CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA; SURGEON TO THE PHILADELPHIA AND GERMAN HOSPITALS.

The Present Aspect of the Iodoform Question.

Dr. W. W. v. Arsdale (*Annals of Surgery*, March, 1889) states his belief that the evidence now before us points to the conclusion that iodoform by attacking the products of bacteria can be of great practical value as a surgical dressing, as we need only to adopt the view that microörganisms introduced into the tissues could be successfully combated by the vital action of the latter, perchance by the leucocytes and the phagocytes, unless the bacteria were assisted in their work by the ptomaines, upon which the iodoform may, and probably does, exert a destructive action. This, however, is as yet merely theory, but some proper conclusions may undoubtedly be deduced from the mass of experimental evidence which is now available.

Since we know that iodoform may contain germs, we should sterilize it before use; this may be done by washing it in sublimate solution. If applied